



## TEXAS DEPARTMENT OF INSURANCE

### Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)

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## MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

### GENERAL INFORMATION

**Requestor Name**

Thomas Pfeil, Jr., MD

**Respondent Name**

Texas Mutual Insurance Company

**MFDR Tracking Number**

M4-15-2849-01

**Carrier's Austin Representative**

Box Number 54

**MFDR Date Received**

May 4, 2015

### REQUESTOR'S POSITION SUMMARY

**Requestor's Position Summary:** "The following bill was audited incorrectly...Rule 134.204, Subsection (J), Subsection (4), Subparagraph (C), (ii), (II). This rule states if a full physical evaluation, with range of motion is performed, reimbursement for the first musculoskeletal body area is \$300.00 and each additional musculoskeletal body area is \$150.00...."

**Amount in Dispute:** \$150.00

### RESPONDENT'S POSITION SUMMARY

**Respondent's Position Summary:** "The following is the carrier's statement with respect to this dispute of 12/29/2014.

1. The requestor, as Designated Doctor, performed MMI and IR exams of the claimant on the date above and then billed Texas Mutual one unit of code 99456-W5-WP. The requestor placed the claimant in DRE category II. For this reason, according to Rule 134.204(j)(4)(C)(ii)(I), Texas Mutual paid the requestor \$150.00 for the DRE model found in the AMA Guides 4<sup>th</sup> edition. However, the requestor seeks reimbursement for the method used at (j)(4)(C)(ii)(II) because (II)(-a-) states 'If full physical evaluation, with range of motion, is performed...\$300 for the first musculoskeletal body area...'

In Appeal No. 022509-s, decided November 21, 2002, the Panel stated:

'If the physician cannot decide into which DRE category the patient belongs, the physician may refer to and use the ROM Model, which is described in Section 3.3j (p. 112). (p. 99). Using the procedures of that model, the physician combines an impairment percent based on the patient's diagnosis with a percent based on the patient's spine motion impairment and a percent based on neurologic impairment, if it is present. (p. 99). The physician uses the estimate determined with the ROM Model to decide placement within one of the DRE categories. (p. 99). The proper DRE category is the one having the impairment percent that is closest to the impairment percent determined with the ROM Model. (p. 99).'

The requestor's documentation shows that he used range of motion as a differentiator to place the claimant in a DRE category. While the Guides do allow for use of the Range of Motion model as a differentiator to place the claimant in a DRE category, the requestor's documentation does not reflect use of the Range of Motion model

but only use of range of motion. If the requestor had used the Range of Motion model then his documentation would show the DRE category as the one having the impairment percentage closest to the impairment percentage of the Range of Motion model.

(j)(4)(C)(ii)(II) must be referring to the Range of Motion model. Otherwise the regulatory agency's interpretation of the 4<sup>th</sup> Edition regarding the use and relationship of the two models is incorrect. Nowhere in the pertinent sections of the Guides does it indicate simple range of motion per se is sufficient as a differentiator to clarify the DRE category..."

**Response Submitted by:** Texas Mutual Insurance Company

### ***SUMMARY OF FINDINGS***

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
December 29, 2014	Designated Doctor Examination (MMI/IR)	\$150.00	\$150.00

### ***FINDINGS AND DECISION***

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

#### **Background**

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.204 sets out fee guidelines for Workers' Compensation specific services.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:
  - CAC-P12 – Workers Compensation Jurisdictional Fee Schedule Adjustment
  - 790 – This charge was reimbursed in accordance to the Texas Medical Fee Guideline.
  - CAC-193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
  - 724 – No additional payment after a reconsideration of services.

#### **Issues**

1. What is the applicable rule for determining reimbursement for the disputed services?
2. What is the total allowable amount for the impairment rating?
3. Is the requestor entitled to additional reimbursement?

#### **Findings**

1. This dispute involves a Designated Doctor Impairment Rating (IR) evaluation of the spine, with reimbursement subject to the provisions of 28 Texas Administrative Code §134.204(j)(4)(C)(ii), which states that "The MAR for musculoskeletal body areas shall be as follows. (I) \$150 for each body area if the Diagnosis Related Estimates (DRE) method found in the AMA Guides 4th edition is used. (II) If full physical evaluation, with range of motion, is performed: (-a-) \$300 for the first musculoskeletal body area."
2. Per 28 Texas Administrative Code §134.204 (j)(3), "The following applies for billing and reimbursement of an MMI evaluation. (C) An examining doctor, other than the treating doctor, shall bill using CPT Code 99456. Reimbursement shall be \$350." The submitted documentation indicates that the Designated Doctor performed an evaluation of Maximum Medical Improvement as ordered by the Division. Therefore, the correct MAR for this examination is \$350.00.

According to the explanation of benefits and the respondent's position statement, the total of \$150.00 was reimbursed by the carrier for the IR of the cervical spine. The carrier alleges that this amount was

appropriately calculated based upon §134.204(j)(4)(C)(ii)(I). The requestor disagrees. In its position, the requestor argues that the carrier should have allowed a total of \$300.00 for the impairment rating of the spine because it asked for reimbursement based upon §134.204(j)(4)(C)(ii)(II)(-a-)[emphasis added]. In order for the requestor to be reimbursed pursuant to rule §134.204(j)(4)(C)(ii)(II)(-a-), the health care provider, in this case, was required to perform a full physical evaluation with range of motion of the spine. Review of the submitted documentation finds that a full physical evaluation with range of motion was performed on the spine. The Division concludes that the impairment rating of the spine is allowed at \$300.00 in accordance with the requirements of §134.204(j)(4)(C)(ii)(II)(-a-).

3. The total allowable for the disputed services is \$650.00. The insurance carrier paid \$500.00. Therefore, additional reimbursement in the amount of \$150.00 is recommended.

### **Conclusion**

This decision is based upon a review of all the evidence presented by the parties in this dispute. Even though all the evidence was not discussed, it was considered. For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is \$150.00.

### ***ORDER***

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of \$150.00 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

### **Authorized Signature**

_____ Signature	Laurie Garnes Medical Fee Dispute Resolution Officer	June 11, 2015 Date
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### ***YOUR RIGHT TO APPEAL***

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012.**

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

**Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.**